Peer-to-peer insurance reviews

Summary of best practices for clinicians' preparation and documentation of peer reviews

Clinicians treating patients with mental health and/or substance use disorders may encounter required discussions with health insurer "peers" in connection with (a) prior authorizations, (b) progress check-ins, (c) medical necessity determinations, and (d) similar "reviews," quality oversight, or appeals. The guidance and "best practices" provided here support better preparation and conduct of peer-to-peer reviews to optimize achieving insurance coverage of medically necessary care.

Potential "agenda" for the call

The reasonable goals for a peer-to-peer review for a treating clinician are:

- Alignment with the peer reviewer regarding the treatment plan, including level of care; as such, sharing new patient information may be timely;
- Clarity/specificity regarding the peer reviewer's competence, preparedness, and basis of assessment for coverage; and
- Go-forward plan for documentation of coverage or path to resolution of coverage

With these goals in mind, below is the outline for an "agenda" and potential talking points for a peer-to-peer discussion. The documentation resources accompanying this guidance support your note-taking for future reference.

A. **Summarize case**, including patient age, gender, demographics, and new clinical information

B. **Peer background and competence** – what clinical training and practice does the clinical reviewer have in support of this review? The independent accreditation organizations who oversee health insurers require relevant clinical competence by reviewers.

C. **Required treatment and level of care for [patient]** – the overriding goal of peer-to-peer discussion to articulate the required treatment plan

D. **Basis of peer reviewer assessment** – understanding peer review's clinical standard of care as applied to this review

E. **Coverage status, clarifications, path to a determination** – is the patient's condition and the treating clinician's plan understood? what possible next steps?

F. **In case of an adverse determination,** If the treating clinician's determination is not approved, then require the peer reviewer to articulate a proposed alternative treatment plan.

G. **Documentation requests** – to request and confirm documentation from the clinical reviewer

Documentation

Cover My Mental Health always recommends documentation of conversations with insurance company representatives about coverage, such as prior authorizations, medical necessity determinations, appeals, formal insurer complaints, regulatory complaints, and litigation.

Contemporaneous documentation of the clinical discussion, as well as provision of a timely medical necessity letter may also be essential to securing the patient's insurance coverage.

After the call: potential follow-ups and next steps

In case of an unsatisfactory outcome, potential follow-up steps may be advisable to overcome denials, secure urgent care approval, or report a reviewer's lack of relevant clinical experience, including:

- Provide a medical necessity letter
- Request a benefit exception
- Request an expedited and/or external review
- Inform patient of potential next steps, including benefit exception request, formal insurer complaint, regulatory complaint.
- File a formal complaint with the insurer
- File a grievance with NCQA and URAC (accreditation organizations for health plans)
- File a complaint with the state and/or federal regulator